SOZO
Counseling Care, Inc.
Hope, healing and wholeness.

Intake Information

3500 S. Phillips Ave., Ste. 121
Sioux Falls, SD 57105
(605)360-2613

Date:_____ Age:_____ Sex:_____

Name:_____

Address:_____

City/State/ZIP:_____

SS#:_____ Date of Birth:_____

Employer:_____ Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____
OK to leave message? Yes No OK to leave message? Yes No OK to leave message? Yes No

Would you like a reminder of scheduled sessions? Yes No If Yes, through Text or Email (circle one)

Email Address: _____

Race (circle one): Asian Black Caucasian Hispanic Native American Other

Spouse's/Partner's Name:_____

Address if different than above:_____

City/State/ZIP:_____

Employer:_____ Address:_____

Health Insurance Information: (please supply insurance card for copying)
Insurance Company:_____ Phone #:_____

Insured Member:_____ **SS#:**_____ **Date of Birth:**_____

ID#:_____ Policy/Group #:_____ Deductible:_____

Mail claims to:_____

Medical History:
Previous counseling?: Yes No Provider Name and Agency:_____

Number of Pregnancies: _____ Number of Live Births: ____

Physical Limitations/Impairment: Yes No Explain:_____

Current Medical Problems:_____

Date of last physical exam: _____ Physician:_____

Current Medications:_____

_____

Referral Source (therapist, physician, pastor, friend, website, etc.):_____

Physician Authorization

If your physician referred you, it is helpful for your counselor at Sozo Counseling Care to be able to confer with your personal physician regarding your diagnosis and treatment.

I give my permission for my therapist at Sozo Counseling Care, Inc. to release records and/or information about my treatment to my physician for the purpose of treatment, planning, and coordinating counseling with my physical health care needs. I may withdraw this consent at anytime in writing or verbally by advising Sozo Counseling Care, Inc.

☐ Yes I AUTHORIZE this release. ☐ No, I DO NOT

(Please continue on back side)

Family Information:

Marital Status (circle one): Single Married Divorced Separated Widowed

List names and ages of children living with you:

Name	Age
_____	____
_____	____
_____	____
_____	____

List names and ages of your children not living with you:

Name	Age
_____	____
_____	____
_____	____
_____	____

Spiritual Information: Many people have spiritual or religious beliefs that shape their lives. Research studies have revealed that spiritual commitment can have an impact on both physical and mental health. Please answer the following to give an accurate assessment of the importance of spirituality in your life.

How religious/spiritual would you say that you are?

❑ Not at all ❑ Not very much ❑ Somewhat ❑ Pretty much ❑ Very much

How often do you study the Bible or other religious literature privately?

❑ Never ❑ Seldom ❑ Occasionally ❑ Frequently ❑ Daily

Other than at mealtime, how often, on average, do you pray to God privately?

❑ Several times per day ❑ Daily ❑ Occasionally ❑ Seldom ❑ Never

On the average, how often have you attended religious worship services (i.e. Sunday morning, Sunday evening, and/or other days) during the last year?

❑ Never ❑ A few times a year ❑ Once or twice a month ❑ Weekly or almost weekly ❑ More than once a week

How would you describe the nature of your relationship to God?

❑ No relationship ❑ Distant relationship ❑ Between distant and close ❑ Close relationship ❑ Very close relationship

Religion:_____ Church:_____

I authorize the use of spiritual interventions in my counseling services. I have initialed below the spiritual interventions which I authorize to be part of my counseling experience:

_____ Prayer for me
_____ Prayer with me
_____ Inner healing prayer ministry
_____ Bible reading
_____ Bible reference
_____ Biblical & religious imagery
_____ Assistance with spiritual formation
_____ Other _____

My signature below indicates I request the professional counseling services of Dr. Dianne S. Heynen, DMin, LPC-MH, BCPCC, QMHP, CEAP. I also authorize the release of information pertinent to my case to my insurance company and I authorize payment of medical benefits to Sozo Counseling Care, Inc. I permit a copy of this authorization to be used in place of the original.

Client Signature:_____ **Date:**_____

Or Parent/Guardian: _____ **Date:**_____